

## STANDARD ENROLLMENT FORM FOR THE MEDICARE-APPROVED DRUG DISCOUNT CARD



Drug Card Sponsor Name	Drug Card Product Name
Enrollment Fee	CMS Sponsor ID Number

### STEP 1: PLEASE ANSWER THE FOLLOWING STATEMENTS

I have Medicare Part A or Medicare Part B. ☐ Yes ☐ No

I **do not** have outpatient prescription drug benefits under my State Medicaid Program. ☐ Yes ☐ No

**If you answered YES to BOTH of the statements above, continue to STEP 2.**

**If you answered NO to either of the statements above,** you may not be eligible for this program. Please see the information on page 1 of the instructions or call the Medicare-approved drug discount card sponsor you have selected for assistance.

### STEP 2: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF

First Name	Middle Initial	Last Name	Date of Birth (month/day/year)	Sex
Residence Street Address			City	State
				ZIP Code
Social Security Number	Medicare ID Number		Telephone Number (with area code)	

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### Step 3: Read all the information

**Release of Information:** By applying for enrollment for a Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program or any other agency with relevant information about me to give CMS or CMS' agents the information needed to determine if I am eligible for a drug discount card.

**Review of Eligibility:** I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that by signing this application I am agreeing to a full investigation or review of my eligibility by states, federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this enrollment form. If you can't sign, a representative may sign for you. Federal law provides for a fine or imprisonment, or both, for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature\_\_\_\_\_Date\_\_\_\_\_

Please return your completed enrollment form to the  
Medicare-approved drug discount card sponsor you selected.

**NOTE:** If you would like to apply for the Medicare-approved drug discount card AND a credit of up to \$600 toward your prescription drugs, please fill out and return the Form CMS-20016-B if you live in the 48 states, Form CMS-20016-D if you live in Alaska, or Form CMS-20016-C if you live in Hawaii.